

Morris View Healthcare Center
Pre-Admission Medical Information
(To be completed by personal physician)

Name _____ Date _____

Allergies: _____

Diet/Restrictions: _____

Please list all medications with dosage and diagnosis:

<u>Medication/Treatment</u>	<u>Dosage</u>	<u>Diagnosis</u>

Summary of Medical History:

Recent Hospitalizations (Date & Reason): _____

Dates of vaccines:

Flu vaccine _____
Pneumovax _____
PPD _____
Tetanus _____

History of: (Date)
VRE _____
MRSA _____
C. Diff _____
Scabies _____

Please include copies of any recent lab work, chest X-ray, EKG, etc.

Physician Signature: _____ Phone: _____